AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name [redacted]	Date of Birth [redacted]	Social Security Number [redacted]
Patient Address [redacted]		

I, or my legal representative, authorize the disclosure and release of my protected health information, as described in section 6 below, to the City of Chicago's Independent Police Review Authority, 10 West 35th Street, Chicago, Illinois 60616, to be used in accordance with the reason stated in Section 7 below.

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **STD TESTS, RESULTS AND TREATMENT (INCLUDING HIV/AIDS), ALCOHOL and DRUG ABUSE TREATMENT, DOMESTIC VIOLENCE HISTORY**, as well as **MENTAL HEALTH TREATMENT**, except psychotherapy notes.
2. I have the right to revoke this authorization at any time by writing to: City of Chicago – Independent Police Review Authority, c/o Investigator _____, 10 West 35th Street, Chicago, IL 60616. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will **NOT** be conditioned upon my authorization of this disclosure.
4. Information disclosed under this authorization might be re-disclosed by the recipient (IPRA), and this re-disclosure may no longer be protected by federal or state law.

5. Name and address of health provider or entity to release this information: CHRIST HOSPITAL	
6. Description of protected health information requested (provide a specific and meaningful description of the information sought, including dates where applicable): EMERGENCY ROOM + ICU (IF ANY) RECORDS FROM 03-04 NOV 2011	
7. Reason for release of information: INVESTIGATION OF LOG # 1049886	8. Date or event on which authorization will expire: AT END OF INVESTIGATION
9. If not the patient, name of legal representative: —	10. Authority to sign on behalf of patient: —

[redacted]
Signature of patient or representative authorized by law

Date: 09 NOV 2011

1049886
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[redacted]